Community Service Network 7 Meeting
DHHS Offices, Biddeford
May 10, 2007

Approved Minutes

Members Present:

- Lois Jones, CSI
- Jeanne Mirisola, NAMI-ME Families
- Elizabeth Sjulander, Saco River Health
- Chris Souther, Shalom House
- Larry Plant, SMMC
- Mary Jane Krebs, Spring Harbor
- Donna Ruble, Sweetser
- Wayne Barter, VOA
- Jen Ouellette, York County Shelters

Members Absent:

- Common Connection Club
- Center for Life Enrichment (vacant)
- Creative Work Systems (excused)
- Goodall Hospital
- Harmony Center
- Job Placement Services, Inc.
- Riverview Psychiatric Center (excused)
- Transition Planning Group
- York Hospital

Others/Alternates Present: Rita Soulard, SMMC; Megan Gendron, York County Shelters; Ron St. James, DHHS.

Staff Present: DHHS/OAMHS: Don Chamberlain, Carlton Lewis, via phone: Marya Faust. Muskie School: Janice Daley.

Agenda Item	Presentation, Discussion
I. Welcome and Introductions	Carlton opened the meeting and participants introduced themselves.
II. Review and Approval of Minutes	Minutes from the April 12 meeting were approved as written.
III. Legislative Updates: Budget, bills, rate standardization	**Legislative Updates/Bills** Don mentioned that public hearings were held yesterday for LD 1855 (relating to the blue paper commitment process) and today for LD 1745 (CSN legislation). Work sessions are scheduled for LD 1855 on May 16th at 1 p.m. and LD 1745 on May 17th at 1 p.m. **Budget/Rate Standardization** Don explained that rate standardization is still in flux. Both Democrats and Republicans do agree on the total amount that must be saved by rate standardization over the next biennium: $20M. They differ on how to split the amount between the two years: Democrats: $6M and $14M for 2008 and 2009, respectively. Republicans: $10M and $10M. The ASO (Administrative Services Organization) RFP (Request for Proposal) has gone out and projected savings has been built into budget proposals.
IV. Training Needs for the CSN Area: July 2007-June 2008	Marya briefly explained OAMHS' current training philosophy (fewer conferences, more skill-building) and the cooperative agreement with the USM Muskie School (which encompasses most of OAMHS trainings and mental health certification programs). She informed of two training topics under development: 1) standardization of crisis plans, and 2) mental health advance directives (working with Helen Bailey of Disability Rights Center on this) and mentioned that another CSN suggested OAMHS develop web-based versions of some of the routine, mandated trainings. She also asked members for feedback on the following questions to help in planning trainings for the coming year: 1) How is recruitment and retention of staff going?

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	2) Specific needs and training topics for next year? 3) Preferred delivery methods of trainings, e.g. web-based, face-to-face, combination? Comments on recruitment/retention: • VOA said they have a substantial long-term core group. Turnover is basically with college student employees. • Health insurance may be more important than increased wages to many. Comments on training topics: • Evidence-based models and interventions. Comments on delivery methods: • Anything web-based would be great. • A member described her positive experiences as a trainer and trainee with "Web-X" sessions, noting there are some "really cool options to make it interactive." (Web-X sessions involve simultaneous telephone and internet connections. Participants are provided with all of the numbers and passwords, etc., to connect. Sessions can be recorded so others can hear it later.) • Web-based trainings can be completed on person's own time. • Another member reminded that not all offices have computer access for all employees, and that networking is very important. • Not having face-to-face dialogues is one downside to web-based trainings. • Can see real advantage to having some of the MHRT-1 curriculum online. **ACTION:** Members may pass on any other ideas or comments to Chris Robinson at 287-4865 or christine.c.robinson@maine.gov.
V. Consent Decree Quarterly Report	Members received copies of the Consent Decree Quarterly Report filed on May 1, 2007. Marya pointed out the added summary section of the Performance and Quality Improvement Standards and brought up a few of the standards for discussion. Highlights: **Standard 1: Have providers treated you with dignity and respect?** Marya said providers deserve credit for doing a good job meeting this standard. **Standard 4: Class members informed about their rights.** Marya said performance is close to compliance and asked members for input on how to improve this: • Spring Harbor gives this information at 3 or 4 levels during hospital stay. • Agency members indicated they go over rights regularly at ISP (Individual Service Plan) reviews and many do use the "one-page handout." • The concern of the "Plaintiff's" is that people understand it, rather than simply receive it. • May be the way the question is asked on the survey—people may not identify "rights of recipients," but know the elements of confidentiality, etc., that were explained to them. **Standard 18: Admissions for whom hospital obtained ISP.** Marya explained that UR nurses check records for this data. • In some cases, the person hospitalized refuses to sign consent and won't tell anyone they work with what's going

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	on. • Don said a standardized crisis plan with all pertinent information would help solve this. In the best world (and according to the Consent Decree Plan), crisis plans would be done in advance of crisis, available 24/7 to the crisis program, and transmitted to the hospital. • ISP needs to be kept up-to-date. Should be done every 90 days or more frequently if person experiences psychiatric crises. • Marya reiterated that all consumers in a community support program are supposed to have a crisis plan, unless they refuse. Carlton mentioned that some call it a "wellness plan," which is considered part of the treatment process. Marya agreed that the plans are not only about inpatient admission. **Standard 33: Recovery.** Marya asked for input on how to better empower and give people hope toward recovery. • Spring Harbor's goal is that recovery is integral to all treatment and day-to-day interventions—staff are trained that way. • Some parts of process, e.g. intake at ERs can seem routine and cold. • It would be great to have focus groups on this—would very much like to know what this is about for consumers—could then do some training about this.
VI. Protocol Guidelines for Hospitalization	Members received a draft of Protocol Guidelines for Psychiatric Hospitalization Process. Don explained that this is aimed more for hospitals without psychiatric units and wished more of them were present for this discussion. Don reviewed some of types of consumer experiences that precipitated these guidelines. • Mary Jane Krebs said that an initiative is getting underway in the Portland area to address mental health issues with area ER staff. MMC is sponsoring a training on June 18. • Re: Face-to-face assessment—be more specific about "timely manner" and describe situations more specifically. • A member shared that the shortest amount of time a family member has spent in an ER (over many visits) is 9 hours. • ER staff at SMMC are not trained in mental health issues. • Maine Medical Center usually does move through medical clearance quickly. Direct communication is key—who's coming, why they're coming, etc. Takes a lot of attention—MMC spent a lot of time working on barriers and issues—target time is now 300 minutes from time person comes in the door to when they go where they're going. • EMMC/MMC have volume to support psychiatric staff—the smaller volumes of many other hospitals do not. Don reviewed the standard for crisis response time: average of 30 minutes. • A provider member said that standards are clear, and <u>great</u>, but it doesn't happen that way. People "sit for <u>hours</u> in the hospital [waiting for crisis worker]." • Another said, "Never seen it be 30 minutes—more like 4 hours." • Another said that 50% of ER visits could be avoided if crisis came to residence—even just for de-escalation. Have experienced crisis refusing to come if person is not suicidal. Don said that "crises are crises" and that people don't have to be suicidal to be seen face-to-face by crisis provider. Clearly, OAMHS wants providers to go other places, rather than ER. A review of CSI's crisis data shows huge proportion are seen in the ER, Don said, and that, as well as wait times, need to be brought down. Additional discussion:

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	• A provider member said the ACT Team doesn't function 24/7—often uses crisis services. Don said that though Maine allows for ACT Teams to be on call, rather than actually staffed 24/, it should be a crisis provider going to see an ACT member in crisis.
VII. Community Support Services	ACT: There are 2 ACT Teams in this CSN, but do not cover all of York County. Discussion did not clearly indicate whether members think there are other areas with enough consumers to support ACT Teams. ICI: A member asked about whether MaineCare "non-cats" are ruled out for community support services. They are not eligible under MaineCare, Don answered, but OAMHS has changed their rules to allow grant funds to be used for non-cats, just as for uninsured. He said that various agencies in every part of Maine have grant funding, but that when those providers "run out of grant money [for the year], it's gone." Regional Team Leaders will look into person's MaineCare status after 6 months of receiving services funded by grant dollars. CI: Data shows people are assigned case managers within 7 days. CSI is the only provider of community support services in this CSN, and at this point in the meeting, CSI's representative was no longer present to contribute to the discussion.
VIII. Peer Support in the Emergency Room	Not discussed.
IX. Outpatient Services	Don said that the data indicates greater than 30-day wait times for outpatient services. Is the issue payor mix? • Saco River Health Services indicated they have opening, but no referrals. • A member stated that many of CSI's caseworkers are "clinical," and if CSI can't take them into their own program, they put them on a waiting list—and do not make referrals to others. (CSI representative not present to discuss.) • Members indicated no shortage of specialty therapies (CBT, DBT) in the CSN, but one provider acknowledged they could do a better job marketing what's available.
X. Medication Management	Don quickly reviewed some of the issues around this service, as follows, with more discussion next month. • Problem of psychiatrist turnover • Medicare and "dual-eligibles" (eligible for both Medicare and MaineCare) are big problem due to low reimbursement rate. (MaineCare pays approximately $200/hour, but Medicare may pay as low as $40 a visit and requires 50% co-pay.)
XI. Policy Council Report	CSN 7 representatives to the Statewide Policy Council were not in attendance to give a report. Will appear on June agenda.
XII. Other	None.
XIII. Public Comment	None.

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XIV. June Agenda Items	Medication Management Community Support Services Outpatient Services Policy Council Report